		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045070

Facility Name: GREENWOOD TERRACE NRSG & REHAB

Address: 225 CASTELLANO DRIVE (Number) SWANSEA (City) 62226 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 235-1300 **Fax #** (618) 235-1208

IDPA ID Number: 36-4384101

Date of Initial License for Current Owners: 10/15/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	133	Intermediate (ICF)	133	48,545	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	237	86,505	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,768	773	2,589	5,130	8
9	SNF/PED					9
10	ICF	18,114	7,186	4,314	29,614	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,882	7,959	6,903	34,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.16%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/15/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/15/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 1,295

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAI # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	156,778	32,165	7,505	196,448		196,448	(1,028)	195,420			1
2	Food Purchase		157,386		157,386		157,386	(2,726)	154,660			2
3	Housekeeping	124,355	9,813	0	134,168		134,168	(244)	133,924			3
4	Laundry	63,089	19,129	3,482	85,700		85,700	0	85,700			4
5	Heat and Other Utilities			114,754	114,754		114,754	0	114,754			5
6	Maintenance	69,145	42,527	54,527	166,199		166,199	(3,725)	162,474			6
7	Other (specify):*			10,868	10,868		10,868	0	10,868			7
8	**TOTAL General Services**	413,367	261,020	191,136	865,523	0	865,523	(7,723)	857,800			8
	B. Health Care and Programs											
9	Medical Director	0		6,200	6,200		6,200	0	6,200			9
10	Nursing and Medical Records	1,309,452	71,077	19,602	1,400,131		1,400,131	1,916	1,402,047			10
10a	Therapy	90,667		247	90,914		90,914	0	90,914			10a
11	Activities	74,704	3,548	323	78,575		78,575	(244)	78,331			11
12	Social Services	28,410		961	29,371		29,371	0	29,371			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			1,454	1,454		1,454	0	1,454			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,503,233	74,625	28,787	1,606,645	0	1,606,645	1,672	1,608,317			16
	C. General Administration											
17	Administrative	92,903		244,542	337,445		337,445	(234,795)	102,650			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			261,347	261,347		261,347	11,575	272,922			19
20	Dues, Fees, Subscriptions & Promotions			49,351	49,351		49,351	(34,220)	15,131			20
21	Clerical & General Office Expenses	99,846	22,613	32,240	154,699		154,699	81,006	235,705			21
22	Employee Benefits & Payroll Taxes			320,016	320,016		320,016	0	320,016			22
23	Inservice Training & Education			1,418	1,418		1,418	0	1,418			23
24	Travel and Seminar			1,149	1,149		1,149	6,680	7,829			24
25	Other Admin. Staff Transportation			17,879	17,879		17,879	0	17,879			25
26	Insurance-Prop.Liab.Malpractice			109,235	109,235		109,235	2,145	111,380			26
27	Other (specify):*			5,292	5,292		5,292	(5,292)	0			27
28	**TOTAL General Administration**	192,749	22,613	1,042,469	1,257,831	0	1,257,831	(172,901)	1,084,930			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,109,349	358,258	1,262,392	3,729,999	0	3,729,999	(178,952)	3,551,047			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB #0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			32,293	32,293		32,293	210,287	242,580			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			82,694	82,694		82,694	254,081	336,775			32
33	Real Estate Taxes			46,924	46,924		46,924	0	46,924			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(295,200)	4,800			34
35	Rent-Equipment & Vehicles			24,754	24,754		24,754	4,321	29,075			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			486,665	486,665	0	486,665	173,489	660,154			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		45,104	236,712	281,816		281,816	0	281,816			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			129,757	129,757		129,757	0	129,757			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	45,104	366,469	411,573	0	411,573	0	411,573			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,109,349	403,362	2,115,526	4,628,237	0	4,628,237	(5,463)	4,622,774			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,214)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,726)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(520)	21		18
19	Entertainment	(22,256)	20		19
20	Contributions	(275)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,154)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,292)	27		24
25	Fund Raising, Advertising and Promotional	(7,700)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,197)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(10,737)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,071)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	67,608	PG 6	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 67,608		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,463)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GREENWOOD TERRACE NRSG & REHAB

ID# 0045070

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -3005	6	1
2	VACATION ACCRUAL	(1,028)	1	2
3	VACATION ACCRUAL	(244)	3	3
4	VACATION ACCRUAL	(720)	6	4
5	VACATION ACCRUAL	(4,478)	10	5
6	VACATION ACCRUAL	(244)	11	6
7	VACATION ACCRUAL	(1,018)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,737)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,028)	0	0	0	0	0	0	0	0	0	0	(1,028)	1
2	Food Purchase	(2,726)	0	0	0	0	0	0	0	0	0	0	(2,726)	2
3	Housekeeping	(244)	0	0	0	0	0	0	0	0	0	0	(244)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,725)	0	0	0	0	0	0	0	0	0	0	(3,725)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,723)	0	0	0	0	0	0	0	0	0	0	(7,723)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,478)	6,394	0	0	0	0	0	0	0	0	0	1,916	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(244)	0	0	0	0	0	0	0	0	0	0	(244)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,722)	6,394	0	0	0	0	0	0	0	0	0	1,672	16
	C. General Administration													
17	Administrative	0	(234,795)	0	0	0	0	0	0	0	0	0	(234,795)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,154)	3,100	9,629	0	0	0	0	0	0	0	0	11,575	19
20	Fees, Subscriptions & Promotions	(35,428)	1,208	0	0	0	0	0	0	0	0	0	(34,220)	20
21	Clerical & General Office Expenses	(1,538)	82,544	0	0	0	0	0	0	0	0	0	81,006	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,680	0	0	0	0	0	0	0	0	0	6,680	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,145	0	0	0	0	0	0	0	0	0	2,145	26
27	Other (specify):*	(5,292)	0	0	0	0	0	0	0	0	0	0	(5,292)	27
28	TOTAL General Administration	(43,412)	(139,118)	9,629	0	0	0	0	0	0	0	0	(172,901)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,857)	(132,724)	9,629	0	0	0	0	0	0	0	0	(178,952)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(17,214)	3,433	224,068	0	0	0	0	0	0	0	0	210,287	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	254,081	0	0	0	0	0	0	0	0	254,081	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	4,800	(300,000)	0	0	0	0	0	0	0	0	(295,200)	34
35	Rent-Equipment & Vehicles	0	4,321	0	0	0	0	0	0	0	0	0	4,321	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,214)	12,554	178,149	0	0	0	0	0	0	0	0	173,489	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(73,071)	(120,170)	187,778	0	0	0	0	0	0	0	0	(5,463)	45

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 6,394	$ 6,394	1
2	V	17	ADMINISTRATIVE	244,542	MR. BELLOWS OWNS 100% OF THIS FACILITY		9,747	(234,795)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		3,100	3,100	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,208	1,208	4
5	V	21	CLERICAL		" "		82,544	82,544	5
6	V	24	TRAVEL		" "		6,680	6,680	6
7	V	26	INSURANCE		" "		2,145	2,145	7
8	V	30	DEPRECIATION		" "		3,433	3,433	8
9	V	34	RENT		" "		4,800	4,800	9
10	V	35	RENT-EQUIPMENT & VEH.		" "		4,321	4,321	10
11	V								11
12	V								12
13	V								13
14	Total			$ 244,542			$ 124,372	$ * (120,170)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 300,000	CASTLEHAVEN AGENCY		$	$ (300,000)	15
16	V	19	ACCOUNTING FEES		" "		4,975	4,975	16
17	V	19	LEGAL		" "		4,204	4,204	17
18	V	19	OTHER PROFESSIONAL		" "		450	450	18
19	V	30	DEPRECIATION		" "		224,068	224,068	19
20	V	32	INTEREST - MORTGAGE		" "		254,081	254,081	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 300,000			$ 487,778	$ * 187,778	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REH/ # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	100.00	SEE ATTACHED	1.31	6.92	SALARY	9,747	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,747		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	501,904	10	$ 92,369	$ 92,369	34,744	$ 6,394	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	140,817	34,744	9,747	2
3	19	PROFESSIOANL FEES	PATIENT DAYS	501,904	10	44,800		34,744	3,100	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462		34,744	1,208	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,659		34,744	9,042	5
6	21	CLERICAL	DIRECT COST	1	1	73,502	73,502	1	73,502	6
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528		34,744	6,680	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995		34,744	2,145	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603		34,744	3,433	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364		34,744	4,800	10
11	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	501,904	10	62,438		34,744	4,321	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 808,537	$ 306,688		$ 124,372	25

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAI # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	ALBANY BANK		X	MORTGAGE	$26,669.00		$	$ 3,392,476		0.0625	$ 254,081	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BK		X	WORKING CAPITAL	DEMAND	04/01	450,000	900,000	DEMAND	PRIME+	38,644	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIOUS	90,000	1,255,345	DEMAND	VARIES	44,050	7
8												8
9	TOTAL Facility Related				$26,669.00		$ 540,000	$ 5,547,821			$ 336,775	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 540,000	$ 5,547,821			$ 336,775	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 9,623	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 9,867	2
3. Under or (over) accrual (line 2 minus line 1).	$ 244	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 46,680	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 46,924	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000	46,173	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 IS A PRORATION OF THE 2000 TAX BILL FOR THE PERIOD IN OPERATION (10/15/00-12/31/00)

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GREENWOOD TERRACE NRSG & REHAB COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0045070

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-15.0-103-001	NURSING HOME	$ 46,173.10	$ 46,173.10
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,173.10	$ 46,173.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,190 B. General Construction Type: Exterior BRICK VENEER Frame MASONRY Number of Stories 1/BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	285,600		$	1
2					2
3	TOTALS	285,600		$ 0	3

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	237				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VENTILATOR ROOF			2001	3,832	103	27.5	103		103	9
10	200 YDS CUSTOM CARPETS/ DRAPES/WALL COVERING - MN DIN			2001	24,870	622	20	622		622	10
11	WALL AIR CONDITIONER			2001	5,583	110	27.5	110		110	11
12	BORDERS/TILES/WALLCOVERING-FRONT LOBBY & CORRIDOR			2001	9,057	226	20	226		226	12
13	MULCH, ROCK, BRICK,FABRIC PLANTS - LANDSCAPING			2001	4,212	140	15	140		140	13
14	WALL COVERING/CARPETS/CUBICLE CURTAINS/VCT TILES			2001	22,334	558	20	558		558	14
15	REMOVE, PRIME AND HANG NEW WALL COVERINGS			2001	32,762	819	20	819		819	15
16	PAINTED AND PREP. RESIDENT ROOMS - 200 WING			2001	6,728	168	20	168		168	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 109,378	$ 2,746		$ 2,746	$ 0	$ 2,746	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 31,135	$ 7,860	$ 6,911	$ (949)	3-10 YRS	$ 14,739	71
72	Current Year Purchases	108,436	21,687	5,422	(16,265)	3-10 YRS	5,422	72
73	Fully Depreciated Assets		227,501	227,501	0			73
74	RELATED PARTY				0			74
75	TOTALS	$ 139,571	$ 257,048	$ 239,834	$ (17,214)		$ 20,161	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 248,949	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 259,794	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 242,580	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,214)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 22,907	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 17,798 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN.	2001 LEXUS RX 300	$ 573.00	$ 6,956	17
18					18
19					19
20					20
21	TOTAL		$ 573.00	$ 6,956	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 83,684	$		$ 83,684	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			31,664			31,664	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			121,364			121,364	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				29,551		29,551	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify):	39-2					15,553		15,553	13
14	TOTAL			$		$ 236,712	$ 45,104		$ 281,816	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,596	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,405,189		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	170,865		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,594,650	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	109,375		15
16	Equipment, at Historical Cost	139,571		16
17	Accumulated Depreciation (book methods)	(40,337)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 208,609	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,803,259	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 347,009	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,464		28
29	Short-Term Notes Payable	1,443,832		29
30	Accrued Salaries Payable	65,077		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,031		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,680		32
33	Accrued Interest Payable	800		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	369,270		36
37	RENT PAYABLE	501,934		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,845,097	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,255,435		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,255,435	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,100,532	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,297,273)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,803,259	$ 0	48

***(See instructions.)**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3	UNREPORTED 2000 BALANCE - 2000 COST REPORT	(745,932)		3
4	NOT REQUIRED SINCE EFFECTIVE DATE IS 10/15/00			4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (745,932)		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,551,341)		7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	( )		13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,551,341)		17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0		23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,297,273)		24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,075,683	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,075,683	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	1,213	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,213	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,076,896	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	865,523	31
32	Health Care	1,606,645	32
33	General Administration	1,257,831	33
	B. Capital Expense		
34	Ownership	486,665	34
	C. Ancillary Expense		
35	Special Cost Centers	281,816	35
36	Provider Participation Fee	129,757	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,628,237	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,551,341)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,551,341)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,150	3,373	$ 71,903	$ 21.32	1
2	Assistant Director of Nursing	406	425	8,594	20.22	2
3	Registered Nurses	5,206	5,506	105,436	19.15	3
4	Licensed Practical Nurses	31,212	32,916	532,116	16.17	4
5	Nurse Aides & Orderlies	55,442	58,005	570,815	9.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,638	7,302	90,667	12.42	8
9	Activity Director	2,444	2,647	32,196	12.16	9
10	Activity Assistants	4,550	5,107	42,508	8.32	10
11	Social Service Workers	2,437	2,659	28,410	10.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,558	6,919	63,759	9.22	14
15	Cook Helpers/Assistants	14,159	14,631	93,019	6.36	15
16	Dishwashers					16
17	Maintenance Workers	4,612	4,905	69,145	14.10	17
18	Housekeepers	17,507	18,230	124,355	6.82	18
19	Laundry	9,534	9,751	63,089	6.47	19
20	Administrator	2,266	2,534	66,627	26.29	20
21	Assistant Administrator	1,658	1,670	26,276	15.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,647	8,094	99,846	12.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,084	2,189	20,588	9.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,510	186,863	$ 2,109,349 *	$ 11.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	314	$ 7,505	1-3	35
36	Medical Director	58	6,200	9-3	36
37	Medical Records Consultant	8	360	10-3	37
38	Nurse Consultant	529	18,042	10-3	38
39	Pharmacist Consultant	168	1,200	10-3	39
40	Physical Therapy Consultant	4	191	10a-3	40
41	Occupational Therapy Consultant	1	56	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	6	323	11-3	44
45	Social Service Consultant	14	961	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,102	$ 34,838		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LINDA SIMMONS	ADMIN		$ 11,750
JACQUELINE HERN	ADMIN		41,839
BRIAN KOONTZ	ASST. ADMIN		39,314
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,903

B. Administrative - Other

Description		Amount
FIRST HEALTHCARE	MANAGEMENT FEES	$ 244,542
TOTAL (agree to Schedule V, line 17, col. 3)		$ 244,542
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		261,347
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 261,347

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,822
Unemployment Compensation Insurance	38,930
FICA Taxes	164,905
Employee Health Insurance	49,961
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,398
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 320,016

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,630
Health Care Worker Background Check	1,264
(Indicate # of checks performed 105)	
MARKETING/ADV/PROMO	35,153
RELATED PARTY	1,208
CONTRIBUTIONS	275
DUES & SUBSCRIPTIONS	1,966
LICENSES & PERMITS	1,063
LESS: CONTRIBUTIONS	(275)
Less: Public Relations Expense	(22,256)
Non-allowable advertising	(7,700)
Yellow page advertising	(5,197)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,131

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,149
RELATED PARTY	6,680
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,829

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	06/2001	$ 3,606	3	$	$	$	$ 601	$ 1,202	$ 1,202	$ 601	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,606		$	$	$	$ 601	$ 1,202	$ 1,202	$ 601	$	$

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 4,518 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 129,757
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: GREENWOOD TERRACE NRSG & REHAB #0045070 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,505	
	REPAIRS & MAINTENANCE		0	
			0	7,505
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,482	
			0	3,482
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,811	
	ELECTRICITY		52,641	
	WATER		29,302	
	CABLE TV - LOBBY		0	
			0	114,754
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,676	
	PAINTING & DECORATING		3,606	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,488	
	ELEVATOR MAINTENANCE & REPAIR		372	
	OUTSIDE LABOR		20,400	
	EXTERMINATING SERVICE		4,130	
	FIRE SERVICE		7,855	
			0	
			0	
			0	54,527
7	**OTHER**			
	SCAVENGER		10,868	
	SECURITY SERVICE		0	10,868
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,200	6,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	360	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	18,042	
			0	
			0	19,602
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	191	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	56	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	247
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	323	
			0	323
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	961	
			0	961
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB **#0045070** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,454	1,454
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	244,542	244,542
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,727	
	ADMINISTRATIVE CONSULTANTS	XIX C	61,000	
	PROFESSIONAL FEES	XIX C	191,620	
			0	261,347
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	22,256	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,700	
	EMPLOYEE WANT ADS	XIX F	9,630	
	CONTRIBUTIONS	VI 20 XIX F	275	
	DUES & SUBSCRIPTIONS	XIX F	1,966	
	LICENSES & PERMITS	XIX F	1,063	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	5,197	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,264	49,351
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		7,661	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	520	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		247	
	TELEPHONE		22,836	
	MESSENGER SERVICE		976	
			0	32,240

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	164,905	
	UNEMPLOYMENT COMPENSATION	XIX D	38,930	
	WORKERS COMPENSATION INSURANC	XIX D	61,822	
	HOSPITALIZATION INSURANCE	XIX D	49,961	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,398	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	320,016
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,418	1,418
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,149	
			0	
			0	1,149
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		17,879	17,879
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		109,235	109,235
27	**OTHER**			
	BAD DEBTS	VI 24	5,292	
			0	5,292

GRAND TOTAL COLUMN 3 OTHER 1,262,392

GREENWOOD TERRACE NRSG & REHAB
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	157,386
LESS SALES TAX	(2,726)
NET FOOD	160112
TOTAL PATIENT CENSUS	34,744
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	104232
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	104232
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	104232
NET FOOD	160112
DIVIDE TOTAL MEALS/YEAR	104232
COST PER MEAL	1.54
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

GREENWOOD TERRACE NRSG & REHAB
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									2,774,965	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,606,645	320,016	425,989	85,700	353,834	937,815	129,757	486,665		2,109,349
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	8,714		1,161			14,879		(24,754)		
CABLE TV			0			0				
CONTRACT NURSING										
INTEREST INCOME							0			
NET VENDING COMMISSIONS							(1,213)			
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(244,542)		244,542		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(5,292)	5,292			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(18,902)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	40,615	0	(40,615)		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	1,615,359	320,016	427,150	85,700	353,834	743,475	114,934	665,838	4,326,306	2,109,349
PER FINANCIAL STATEMENTS	1,615,359	320,016	427,150	85,700	353,834	743,475	114,934	665,838	(1,551,341)	2,109,349
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									(1,551,341)	

GREENWOOD TERRACE NRSG & REHAB - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		86,505			0			86,505	0		
CENSUS DAYS		34,744			0			34,744	0		
OCCUPANCY %		40.16%			#DIV/0!				#DIV/0!		
SALARIES											
TOTAL General Services	8-1	413,367	8.94%	11.90				413,367			
Social Services	12-1	28,410	0.61%	0.82				28,410			
TOTAL Health Care and Programs	16-1	1,503,233	32.52%	43.27				1,503,233			
Clerical & General Office Expenses	21-1	99,846	2.16%	2.87				99,846			
TOTAL General Administration	28-1	192,749	4.17%	5.55				192,749			
TOTAL Operation Expense	29-1	2,109,349	45.63%	60.71				2,109,349			
ADJUSTED TOTALS											
Food	2-8	154,660	3.35%	4.45				154,660			
Heat and Other Utilities	5-8	114,754	2.48%	3.30				114,754			
Maintenance	6-8	162,474	3.51%	4.68				162,474			
TOTAL General Services	8-8	857,800	18.56%	24.69				857,800			
Administrative	17-8	102,650	2.22%	2.95				102,650			
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	272,922	5.90%	7.86				272,922			
Fees, Subscriptions, Promotions	20-8	15,131	0.33%	0.44				15,131			
License Fee-IDPA	Pg21	0	0.00%	0.00				0			
License Fee-Other	Pg21	1,063	0.02%	0.03				1,063			
Clerical & General Office Expenses	21-8	235,705	5.10%	6.78				235,705			
Employee Benefits & Payroll Taxes	22-8	320,016	6.92%	9.21				320,016			
Payroll Taxes	Pg21	203,835	4.41%	5.87				203,835			
W/C Insurance	Pg21	61,822	1.34%	1.78				61,822			
Health Insurance	Pg21	49,961	1.08%	1.44				49,961			
Inservice Training & Education	23-8	1,418	0.03%	0.04				1,418			
Travel and Seminar	24-8	7,829	0.17%	0.23				7,829			
Other Admin. Staff Transportation	25-8	17,879	0.39%	0.51				17,879			
Insurance-Prop.Liab.Malpractice	26-8	111,380	2.41%	3.21				111,380			
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	1,084,930	23.47%	31.23				1,084,930			
TOTAL Operation Expense	29-8	3,551,047	76.82%	102.21				3,551,047			
Real Estate Taxes	33-3	46,924	1.02%	1.35				46,924			
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	4,622,774	100.00%	**133.05**				4,622,774			
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1714669.77	37.09%	**49.35**	#DIV/0!	#DIV/0!	**#DIV/0!**	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0!**

GREENWOOD TERRACE NRSG & REHAB - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 601 from Page 22 and -3606 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-254081

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-227501

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.